T OP and TFMDP POINT OF CONTACT PROGRAM

May 1999

TOP AND TFMDP POINT OF CONTACT PROGRAM

INTRODUCTION

The Point of Contract (POC) Program for TRICARE Overseas Program (TOP) healthcare claims has been in operation since 1991. The POC Program is designed to provide beneficiaries and host nation providers assistance with filing TRICARE claims for care received in foreign countries. This liaison service is designed to ensure timely overseas claim filing and payment. With the expansion of the POC program to include TRICARE Family Member Dental Plan (TFMDP) claims, beginning May 1999, the Department continues to provide another important tool to ensure beneficiary access to quality host nation healthcare. Oversight and support of a designated POC by the various Uniformed Services Branches is critical to assure the continued success of the POC program.

BACKGROUND

Military family members in foreign countries have had trouble getting medical and dental care from host nation providers for the following reasons:

- Delays in beneficiary/provider filing of TRICARE Overseas Program (TOP) claims;
- Delays in host nation mail service;
- Delays in host nation provider payment by the beneficiary, upon receipt of TOP payment.

To reduce these delays, TRICARE Management Activity (TMA) established dedicated foreign claims processing departments to handle TOP and TFMDP claims. Each specialized foreign claims processing department has a dedicated staff to process only TOP or TFMDP claims, dedicated data fax capabilities, and a dedicated post office box for the receipt of TOP or TFMDP claims and correspondence. The TFMDP dedicated foreign claims processing department also has electronic mail capability for receiving TFMDP correspondence.

Although the volume of TOP and TFMDP claims is small, the claims receive priority processing. The special handling provided by the dedicated TOP and TFMDP foreign claims processing departments, combined with the valuable liaison service provided by local designated POCs results in the retention of quality host nation providers to treat the Department's beneficiary population while on overseas assignment.

WHO MAY QUALIFY TO BE A POINT OF CONTACT?

A designated Point of Contact (POC), must be either:

- An Active Duty military member; or
- A civilian employee working for, and under the oversight of, the military/U.S. Government.

POC DESIGNATION

Requests for POC designation must be in writing, signed by the POC's Commanding Officer, and submitted to the TRICARE Management Activity, Chief, Managed Care Support Office, 16401 East Centretech Parkway, Aurora, CO 80011-9043. The request must include the POC's complete mailing addresses, telephone, and fax numbers, and email address when available.

Upon approval, TMA will notify the requestor and the contractors via fax and mail.

DUTIES OF THE POINTS OF CONTACT

Designated POCs must:

- Assist the Uniformed Services, TRICARE beneficiaries, active duty members, where appropriate, and host nation providers with completion of and filing TOP and TFMDP claims with the appropriate claims processor.
- Develop procedures for the coordination, control and tracking of either faxed or mailed claims from within their areas of responsibility to the appropriate claims processing contractors. This process must include the receipt of and distribution of foreign drafts/U.S. dollar checks/explanation of benefits (EOB) received from the contractors as payment for services rendered by host nation providers.
- Establish and maintain a file for the original claim and all related correspondence.
- Provide their ***commercial***, not DSN or AUTOVON, telephone, and fax numbers on the fax cover sheet with each fax claim submission.
- Ensure the beneficiary/provider has provided complete and accurate information prior to forwarding the claim(s) to the appropriate claims processor (i.e., authorization,

Nonavailability Statement (NAS), provider address, payee designation, claim form signed by the beneficiary, etc.).

- *NOTE: For TFMDP dental claims*, a properly completed "Non-Availability and Referral Form" must accompany the dental claim form, except for non-orthodontic services performed in remote locations. The form must be issued by the enrolled family member's servicing overseas dental treatment facility (ODTF), or the appropriate overseas lead agent, or their designee, depending on where the family member lives and the dental services that are performed. The POC *may not* complete this form. The TFMDP contractor has published a reference guide to assist ODTFs, overseas lead agents and POCs in the management of TFMDP dental claims. This "Authorization and Referral Manual" documents the proper procedures for the issuance of TFMDP authorizations, referrals and claims payment processes. This manual takes precedence over any potential conflicting instructions in this publication.

- Attach copies of all related itemized bills (not receipts) with the claim.

- Ensure claims for *adjunctive dental care* are sent to the appropriate TRICARE contractor responsible for processing medical claims and not the TFMDP contractor.

- Provide the specialized foreign claims processors any additional information that may be required by the contractor(s) to finalize the processing of a claim. All designated POCs may use fax inquiries to request information on the status of a specific claim. TFMDP claims inquiries may also be submitted via electronic mail and must include a complete return e-mail address and commercial telephone and fax numbers.

- Use priority pouch mail for receipt of foreign drafts/U.S. dollar checks/EOBs from the TRICARE contractors.

- Distribute foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries or host nation providers immediately upon receipt.

- Report unresolved claims problems or issues between the TRICARE contractor and the POC concerning policies or program requirements for:

  - TOP issues to the TRICARE Management Activity, Chief, Managed Care Support Office, 16401 East Centretech Parkway, Aurora, CO 80011-9043.

  - TFMDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretech Parkway, Aurora, CO 80011-9043.

- Educate local beneficiaries and host nation providers on the correct procedures for filing their claims.

- Stress the importance of filing claims within 30 days following receipt of TOP or TFMDP since timely filing ensures prompt payment of care received.

WHAT THE TRICARE CONTRACTORS DO

The TOP and TFMDP dedicated claims processing departments must:

- Assist the TOP and TFMDP POCs, Uniformed Services, TRICARE beneficiaries, active duty members where appropriate, and host nation providers with information on the completion of and filing of claims with the appropriate claims processor.

- Develop internal procedures for the coordination, control and tracking of faxed or mailed claims from receipt to final processing. This includes, but is not limited to, storage/maintenance of the claim and all related correspondence, microfilming/imaging of claims upon receipt, the issuance of foreign drafts/U.S. dollar checks/EOBs, and development procedures for missing information needed to process the claim to completion.

- Provide a dedicated P.O. box for the receipt of TOP and TFMDP claims.

- Provide a dedicated fax number for the receipt of POC claims.

- Accept only faxed claims/inquires/information faxed by an officially designated POC or an alternate POC. Electronic mail may also be used for TFMDP inquiries/information.

- Verify beneficiary eligibility for TOP or TFMDP benefits.

  - For TOP claims, a copy of the front and back of the dependent ID card may be sent in with the TOP claim and may be used as eligibility verification by the contractor when the family member is not enrolled in DEERS.

  - For TFMDP claims, the family member must first be enrolled in DEERS and the TFMDP, and the sponsor must pay the appropriate premium, before services can be rendered and his/her claims processed. The sponsor should verify on his/her Leave and Earnings Statement (LES) that the correct payroll deduction has been taken. The sponsor is also advised to contact the TFMDP contractor before

receiving services to ensure that the proper enrollment information has been received and to confirm the actual coverage date.

- Review claims to ensure the beneficiary/provider has provided complete and accurate information prior to submitting claims for processing/payment.

- Process TOP claims using guidelines in TRICARE Policy Manual, Chapter 12, and TRICARE Operations Manual, Part II, Chapter 22.

- Process TFMDP claims per contract requirements and the guidelines outlined in the "Authorization and Referral Manual".

- Be able to translate claims submitted in a foreign language.

- Pay claims using the exchange rate in effect on the last date of service listed on the claim.

- Make payment as follows:

  - For TOP Claims:
  - Issue foreign currency drafts for TOP claims. Payment may not be changed to a U.S. dollar check after the TRICARE contractor has issued a foreign draft.

  - For TFMDP Claims:
  - Issue foreign currency drafts for TFMDP claims submitted by providers via POCs.
  - Issue U.S. dollar checks for TFMDP claims submitted by a sponsor/family member, via POCs. Payment may not be changed to local currency after the U.S. dollar check has been issued.

  - For TOP and TFMDP Claims:
  - Issue foreign currency drafts for both TOP and TFMDP claims when the sponsor/family member requests payment in local foreign currency only at the time the claim is submitted.

    - Note: Foreign drafts are good indefinitely and may be cashed at any time. U.S. dollar checks are good for a limited period of time and must be reissued by the TRICARE contractors upon expiration of the check before the check can be cashed.

- Use priority pouch mail for the mailing of foreign drafts/U.S. dollar checks/EOBs to appropriate sponsors/beneficiaries and/or host nation providers for claims submitted

via POCs. The priority pouch mail must be sent using the fastest means available to the POC's location.

- Report unresolved claims problems or issues between the POC and the TRICARE contractor concerning policies or program requirements for:

  - TOP issues to the TRICARE Management Activity, Chief, Managed Care Support Office, 16401 East Centretech Parkway, Aurora, CO 80011-9043.

  - TFMDP issues to the TRICARE Management Activity, Chief, Special Contract Operations Office, 16401 East Centretech Parkway, Aurora, CO 80011-9043.

HELPFUL HINTS

- Make sure the TOP and TFMDP claim form is completed and signed by the patient or by the parent (or responsible party) in the case of a minor.

- Do not send TOP or TFMDP claims provided to two different beneficiaries by the same provider on the same claim form. Each beneficiary should file claims on a separate form.

- Remember the TOP claims department processes only healthcare and adjunctive dental claims for services provided in foreign countries and TOP Prime healthcare provided in the U.S.

- Remember the TFMDP claims department processes all TFMDP claims for enrolled family members, regardless of where the service was performed.

- Remember to remind beneficiaries and providers that the TOP and TFMDP programs do not share the cost of all types of healthcare or dental care. Therefore, TRICARE payment for every service received can't be guaranteed.

- Remember to use the beneficiary's claim number listed on the EOB when making specific claims inquiries to the TOP and TFMDP contractors.

  - Note: Do not send a new claim when the first claim has been denied or was processed incorrectly. Contact the appropriate TRICARE contractor for assistance.

SUMMARY

The TRICARE contractors' foreign healthcare and dental claims processing department has produced excellent results for the installations using the system. However, it can only be effective if the Services designate POCs and the designated POCs understand the TOP and TFMDP programs and the claims processing requirements. The POC must also communicate with the TRICARE contractors' foreign healthcare and dental claims departments on a regular basis.

Although the POC program is not for all locations and situations, the use of the POC concept does improve the situation for accessing and ensuring prompt payment to host nation providers in countries that take full advantage of the system.

The attached flowchart summarizes the recommended foreign claims submission process.

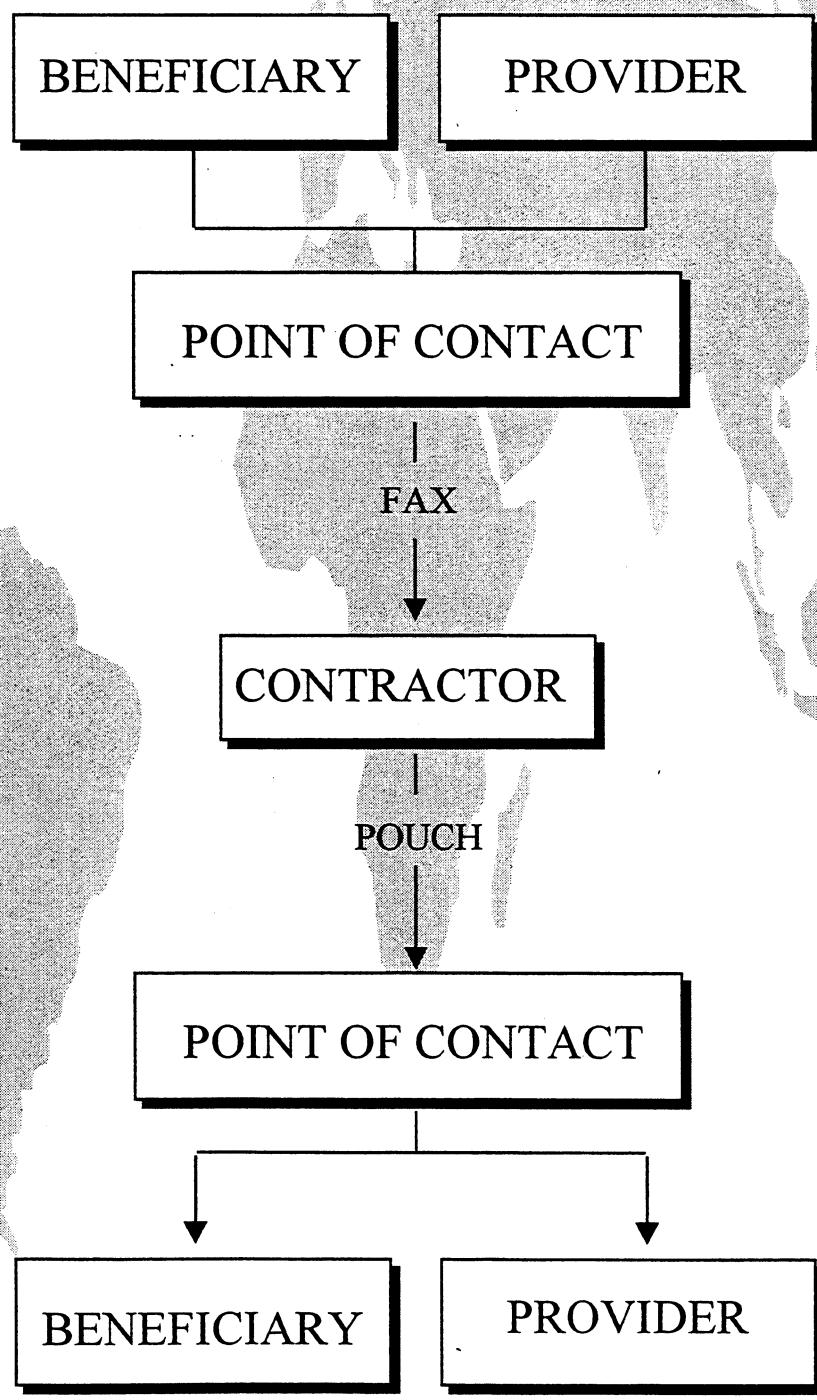
TOP CLAIM FORMS

There are two different claim forms that may be used when filing TOP healthcare claims: the DD Form 2520 (the yellow one) and the new DD 2642 (the white one). Front and back copies of each of the claim forms are attached.

Directions for completing each claim form are included on the back of each form. If you need help in filling out the claim forms or have questions, please contact either the Overseas Lead Agent for your area or contact the appropriate TRICARE contractor for assistance.

TRICARE

RECOMMENDED FOREIGN CLAIMS METHOD



CHAMPUS/CHAMPVA CLAIM FORM

For services or supplies provided by civilian sources of medical care.
Read cover instructions and the back of this form **before completing and signing!**

Form Approved
OMB No. 0704-0084
Expires Nov 30, 1993

SECTION I - PATIENT INFORMATION

1. PATIENT'S NAME *(Last, First, Middle Initial)*

2. PATIENT'S DATE OF BIRTH *(MMDDYY)*

3. PATIENT'S ADDRESS *(Street, City, State, and ZIP Code)*

TELEPHONE *(Include Area Code)*

4. PATIENT'S SEX *(X one)*
MALE | FEMALE

5. MILITARY/VA IDENTIFICATION CARD INFORMATION
a. CARD NO.

b. ISSUE DATE *(MMDDYY)* | c. EFFECTIVE DATE *(MMDDYY)* | d. EXPIRATION DATE *(MMDDYY)*

6. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)*
SELF | SPOUSE | NATURAL or ADOPTED CHILD | STEPCHILD | OTHER *(Specify)*:

14a. ARE YOU COVERED BY ANY OTHER HEALTH INSURANCE PLAN OR PROGRAM TO INCLUDE HEALTH COVERAGE AVAILABLE THROUGH OTHER FAMILY MEMBERS? IF YES, ENTER NAME OF OTHER PLAN OR PROGRAM. — YES | NO

ADDRESS *(Include ZIP Code)*

b. TYPE OF COVERAGE *(X one)*
Employment (Group) | Private (Non-Group) | MEDICAID | MEDICARE | Student Plan | Other *(Specify)*

c. OTHER IDENTIFICATION NUMBER

d. EFFECTIVE DATE *(MMDDYY)*

e. OTHER PROGRAM THROUGH EMPLOYMENT? EMPLOYER NAME — YES | NO

15. REASON FOR CONDITION *(X all that apply)*

	YES	NO
a. WORK RELATED		
b. MILITARY SERVICE RELATED		
c. AUTOMOBILE ACCIDENT RELATED		

16. INPATIENT/OUTPATIENT CARE
OUTPATIENT
INPATIENT-SKILLED NURSING FACILITY
INPATIENT HOSPITAL WITHIN CATCHMENT AREA *(Attach DD Form 1251)*
INPATIENT-EMERGENCY
INPATIENT HOSPITAL -OUTSIDE CATCHMENT AREA
PROGRAM FOR THE HANDICAPPED
INPATIENT-OTHER

17. DESCRIBE CONDITION FOR WHICH YOU RECEIVED TREATMENT. IF AN INJURY, NOTE HOW IT HAPPENED.

18. SIGNATURE OF PATIENT OR AUTHORIZED PERSON, CERTIFIES CLAIM INFORMATION AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION. READ INSTRUCTIONS AND REVERSE BEFORE SIGNING.
a. SIGNATURE | b. DATE SIGNED | c. RELATIONSHIP TO PATIENT

SECTION II - SPONSOR INFORMATION

7. SPONSOR'S NAME *(Last, First, Middle Initial)*

8. SPONSOR'S SOCIAL SECURITY NO. OR VA ID NO.

9. VA STATION NO.

10. SPONSOR'S DUTY STATION OR ADDRESS FOR RETIREES

TELEPHONE *(Include Area Code)*

11. SPONSOR'S BRANCH OF SERVICE *(X one)*
USA | USAF | USMC | USN | USCG | USPHS | NOAA | VA

12. SPONSOR'S GRADE/RANK

13. SPONSOR'S STATUS *(X one)*
ACTIVE DUTY | RETIRED | DECEASED

SECTION III - PHYSICIAN/OTHER PROVIDER (Items 19 through 33 are to be completed by the physician or other provider)

19. REFERRING PHYSICIAN
a. NAME
c. TELEPHONE *(Include Area Code)*
b. ADDRESS *(Include ZIP Code)*
d. *(X one)*
PRIVATE PRACTICE
UNIFORMED SERVICES

20. FACILITY WHERE SERVICES RENDERED *(Other than home/office)*
a. NAME
b. ADDRESS *(Include ZIP Code)*

21. PROVIDER OF SERVICES
ATTENDING PHYSICIAN
OTHER *(Specify)*

22. HOSPITALIZATION INFORMATION
a. ADMISSION DATE *(MMDDYY)* | b. DISCHARGE DATE *(MMDDYY)*

23. LAB WORK OUTSIDE YOUR OFFICE?
YES | NO | IF YES, CHARGES:

24. DIAGNOSIS, SYMPTOM OR NATURE OF ILLNESS OR INJURY *(Relate diagnosis to procedure in column 27e. by reference to numbers 1, 2, 3, or DX Code)*
1.
2.
3.

25. SERVICES PROVIDED

a. DATES OF SERVICE MO/DAY/YEAR	b.* PLACE OF SERVICE	c. PROCEDURE CODE IDENTIFY:	d. DESCRIBE PROCEDURES/SUPPLIES FOR EACH DATE, SUBMIT REPORT EXPLAINING UNUSUAL SERVICES OR CIRCUMSTANCES	e. DIAGNOSIS CODE	f. CHARGES	LEAVE BLANK

26. PATIENT'S ACCOUNT NO.

27. PROVIDER'S SOCIAL SECURITY NO.

28. PROVIDER'S EMPLOYER I.D. NO.

29. PHYSICIAN OR OTHER PROVIDER
a. NAME
b. ADDRESS *(Include ZIP Code)*
c. TELEPHONE *(Include Area Code)*
d. PROVIDER NO.

g. TOTAL CHARGES
$

30. AMT. PD. BY BENEFICIARY
$

31. AMT. PD BY OTHER INSURANCE
$

32. AGREEMENT TO PARTICIPATE *(Read reverse)*
YES | NO

33. PHYSICIAN OR OTHER PROVIDER *(Read reverse before signing)*
a. SIGNATURE | b. DATE SIGNED

DD Form 2520, DEC 90

Previous edition may be used.

Privacy Act Statement

AUTHORITY: 44 U.S.C. §3101; 10 U.S.C §§1079 and 1086; 38 U.S.C §613; E.O. 9397.

PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Department of Veterans Affairs, the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

PATIENT / SPONSOR INFORMATION - ITEMS 1 - 18

Items 1 through 18 must be completed and the certificate signed by the beneficiary/patient if he/she is 18 years of age or older. If the beneficiary/patient is unable to sign on his/her own behalf, refer to Fact Sheet 12, "How to File a CHAMPUS Claim." The sponsor may sign for any beneficiary/patient under 18 years of age, or in the absence of the sponsor, the other parent, the beneficiary/ patient or beneficiary/patient's guardian may sign. (NOTE: For privacy reasons, a beneficiary/patient under 18 years of age may sign his/her own claim form.)

BENEFICIARY / PATIENT CERTIFICATION - ITEM 18

By signing Item 18 of this CHAMPUS/CHAMPVA claim form, I certify that to the best of my knowledge and belief the information provided in Items 1 through 17 is complete and correct. I further authorize the release of any medical information necessary to adjudicate and process this claim to the Federal Government including the CHAMPUS Contractor. I also authorize the release of, or obtaining of, medical and/or other coverage information to and from another organization with which I have the other medical benefits plan or health insurance coverage.

If I am submitting this claim for direct reimbursement to me, my signature further certifies that the specific medical services/supplies for which I am claiming benefits were actually rendered to me on the dates indicated and that the attached itemized statement represents a legal obligation to pay.

(NOTE: The above is also certified if Item 18 is signed by the sponsor, other parent or guardian.)

PROVIDER PARTICIPATION - ITEM 32

By checking "Yes" in Item 32 (and signing in Item 33) of the CHAMPUS/CHAMPVA claim form, I agree to submit this claim to the appropriate CHAMPUS Contractor as a participating provider. I understand that I agree to accept the CHAMPUS-determined allowable charge as the total charge for medical services/supplies listed on the claim form. I will accept the CHAMPUS-determined allowable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-shared amount and deductible, if any, paid by or on behalf of the beneficiary/patient, as full payment for the medical services/supplies. I will make no attempt to collect from the beneficiary/patient (or sponsor) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS agrees to make any benefits payable directly to me, if I submit a claim as a participating provider.

(**Any alteration** of this statement by the provider may result in the claim being returned or processed as a non-participating claim with payment made to the beneficiary.)

PROVIDER CERTIFICATION - ITEM 33

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by CHAMPUS regulations.

For services to be considered as 'incident' to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental, part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included in the physician's bill.

I further certify that I am not an intern, resident, or otherwise in a training status for which I am receiving compensation for services listed on this claim.

I further certify that I am not (1) an active duty member of the Uniformed Services; (2) a civilian employee of the United States Government; or (3) a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536).

IMPORTANT - READ CAREFULLY

Federal Laws (18 USC 287 and 1001) provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS/CHAMPVA claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for CHAMPUS/CHAMPVA beneficiaries; or where a participating provider bills the beneficiary/patient (or sponsor) for amounts over the CHAMPUS-determined reasonable charge; or where a beneficiary/patient (or sponsor) fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL BE RETURNED.

CHAMPUS CLAIM
PATIENT'S REQUEST FOR MEDICAL PAYMENT

Form Approved
OMB No. 0720-0006
Expires Jun 30, 1996

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO EITHER OF THESE ADDRESSES. RETURN COMPLETED FORM TO THE APPROPRIATE CHAMPUS CLAIMS PROCESSOR. IF YOU DO NOT KNOW WHO YOUR CLAIMS PROCESSOR IS, CONTACT A HEALTH BENEFITS ADVISOR OR OCHAMPUS (303) 361-1000.

PRIVACY ACT STATEMENT

AUTHORITY: 44 U.S.C. 3101; 10 U.S.C. 1079 AND 1086; 38 U.S.C. 613; E.O. 9397.

PRINCIPAL PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Department of Health and Human Services and/or the Department of Transportation consistent with their statutory administrative responsibilities under CHAMPUS; to the Department of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service and private collection agencies in connection with recoupment claims; and to Congressional offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURE: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim.

IMPORTANT - READ CAREFULLY

Federal Laws *(18 U.S.C. 287 and 1001)* provide for criminal penalties for knowingly submitting or making any false, fictitious or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons knowingly use an unauthorized Identification Card in filing of a CHAMPUS claim; or where providers submit claims for treatment, supplies or equipment not rendered to, or used for CHAMPUS beneficiaries; or where a participating provider bills the beneficiary/patient *(or sponsor)* for amounts over the CHAMPUS-determined allowable charge; or where a beneficiary/patient *(or sponsor)* fails to disclose other medical benefits or health insurance coverage.

INCOMPLETE CLAIM FORMS WILL DELAY PAYMENT

NONAVAILABILITY STATEMENT REQUIREMENTS: If the patient resides within the catchment area of a Military Treatment Facility (MTF) or Uniformed Services Treatment Facility *(USTF) (generally within a 40-mile radius of the MTF or USTF)*, the patient must obtain a Nonavailability Statement for most inpatient care that is not a bona fide emergency. A Nonavailability Statement is also required for some outpatient procedures. ***Contact your Health Benefits Advisor for more information. The claims processor will deny your claim if you need a nonavailability statement authorization and do not have one.***

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ITEMIZED BILL: Ask your provider to complete the HCFA Form 1500 for you. If the provider refuses, complete this form and attach an itemized bill which must be on the provider's billing letterhead. The bill must contain the following information:

1. Doctor's or provider's name/address *(the one that actually provided your care)*. If there is more than one provider on the bill, circle his/her name;
2. Date of each service;
3. Place of each service;
4. Description of each surgical or medical service or supply furnished;
5. Charge for each service;
6. The diagnosis should be included on the bill. If not, make sure that you've completed block 8a on the form.

DRUGS: All prescriptions require the name of the patient; the name, strength, and quantity of each drug; the prescription number of each drug; the name and address of the pharmacy; and, the name and address of the prescribing physician. Billing statements showing only total charges, or canceled checks, or cash register and similar type receipts are not acceptable as itemized statements

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TIMELY FILING REQUIREMENTS: All claims must be filed no later than one year after the services are provided; or for inpatient care, one year from the date of discharge. Contact a CHAMPUS Health Benefits Advisor or OCHAMPUS if you need the name and address of your claims processor. If a claim is returned for additional information, it must be resubmitted by the filing deadline, or within 90 days of the notice -- whichever date is later.

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WHERE TO OBTAIN ADDITIONAL FORMS: You may obtain additional claim forms from your claims processor, the Health Benefits Advisor at the nearest military treatment facility or OCHAMPUS, Aurora, CO 80045-6900.

*** REMINDER ***

Before submitting your claim to the claims processor be sure that you have:

1. **Completed all 12 blocks on the form.** *If not signed, the claim will be returned.*
2. Verified that the sponsor's SSN is correct.
3. Attached your provider's or supplier's bill which specifically identifies the doctor/suppler that provided your care.
4. Attached an Explanation of Benefits if there is other health insurance or Medicare supplemental insurance.
5. Obtained a Nonavailability Statement if required *(see information above).*
6. Attached DD Form 2527, "Statement of Personal Injury - Possible Third Party Liability" if accident or work related. See instruction number 7 on reverse side.
7. Ensured that the patient's name, sponsor's name and sponsor's SSN are on all attachments.
8. Made a copy of this claim and attachments for your records.

1. PATIENT'S NAME *(Last, First, Middle Initial)*	2. PATIENT'S TELEPHONE NUMBER *(Include Area Code)* DAYTIME ( ) EVENING ( )
3. PATIENT'S ADDRESS *(Street, Apt. No., City, State, and ZIP Code)*	4. PATIENT'S RELATIONSHIP TO SPONSOR *(X one)* ☐ SELF ☐ STEPCHILD ☐ SPOUSE ☐ OTHER *(Specify)* ☐ NATURAL OR ADOPTED CHILD

5. PATIENT'S DATE OF BIRTH *(MM DD YY)*	6. PATIENT'S SEX *(X one)*	7. IS PATIENT'S CONDITION *(X both if applicable)*		
	☐ MALE ☐ FEMALE	ACCIDENT RELATED?	☐ YES	☐ NO
		WORK RELATED?	☐ YES	☐ NO

8a. DESCRIBE CONDITION FOR WHICH THE PATIENT RECEIVED TREATMENT, SUPPLIES OR MEDICATION. IF AN INJURY, NOTE HOW IT HAPPENED. REFER TO INSTRUCTION BELOW.	8b. WAS PATIENT'S CARE *(X one)* ☐ INPATIENT? ☐ OUTPATIENT? ☐ DAY SURGERY?

9. SPONSOR'S NAME *(Last, First, Middle Initial)*	10. SPONSOR'S SOCIAL SECURITY NUMBER

11. OTHER HEALTH INSURANCE COVERAGE

a. Is patient covered by any other health insurance plan or program to include health coverage available through other family member? If yes, check the "Yes" block and complete blocks 11 and 12 (see instructions below). If no, you must check the "NO" block and complete block 12. Do not provide CHAMPUS supplemental insurance information, but do report Medicare supplements. — YES ☐ NO ☐

b. TYPE OF COVERAGE *(Check all that apply)*

☐ (1) EMPLOYMENT *(Group)* ☐ (3) MEDICINE ☐ (5) MEDICARE SUPPLEMENTAL INSURANCE
☐ (2) PRIVATE *(Non-Group)* ☐ (4) STUDENT PLAN ☐ OTHER *(Specify)*

	c. NAME AND ADDRESS OF OTHER HEALTH INSURANCE *(Street, City, State, and ZIP Code)*	d. INSURANCE IDENTIFICATION NUMBER	e. INSURANCE EFFECTIVE DATE *(MM DD YY)*
INSURANCE 1			
INSURANCE 2			

12. SIGNATURE OF PATIENT OR AUTHORIZED PERSON CERTIFIES CORRECTNESS OF CLAIM AND AUTHORIZES RELEASE OF MEDICAL OR OTHER INSURANCE INFORMATION.

a. SIGNATURE	b. DATE SIGNED *(MM DD YY)*	c. RELATIONSHIP TO PATIENT

HOW TO FILL OUT THE CHAMPUS FORM

You must attach an itemized bill (see front of form) from your doctor/supplier for CHAMPUS to process this claim.

1. Enter patient's last name, first name and middle initial as it appears on the military ID Card. Do not use nicknames.
2. Enter the patient's daytime telephone number and evening telephone number to include the area code.
3. Enter the complete address of the patient's place of residence at the time of service *(street number, street name, apartment number, city, state, ZIP Code)*. Do not use a Post Office Box Number except for Rural Routes and numbers. Do not use an APO/FPO address unless the patient was actually residing overseas when care was provided.
4. Check the box to indicate patient's relationship to sponsor. If "Other" is checked, indicate how related to the sponsor; e.g., former spouse.
5. Enter patient's date of birth *(month/day/year)*.
6. Check the box for either mail or female (patient).
7. Check box to indicate if patient's condition is accident related, work related or both. If accident or work related, the patient is required to complete DD Form 2527, "Statement of Personal Injury-Possible Third Party Liability CHAMPUS/CHAMPVA." The form may be obtained from the claims processor, Health Benefits Advisor or OCHAMPUS.
8a. Describe patient's condition for which treatment was provided; e.g., broken arm, appendicitis, eye infection. If patient's condition is the result of an injury, report how it happened; e.g., fell on stairs at work, car accident.
8b. Check the box to indicate where the care was given.
9. Enter the Sponsor's last name, first name and middle initial as it appears on the military ID Card. If the sponsor and patient are the same, enter "same."
10. Enter the Sponsor's Social Security Number *(SSN)*.
11. By law, you must report if the patient is covered by any other health insurance to include health coverage available through other family members. If the patient has supplemental CHAMPUS insurance, do not report. You must, however, report Medicare supplemental coverage. Block 11 allows space to report two insurance coverages. If there are additional insurances, report the information as required by Block 11 on a separate sheet of paper and attach to the claim.

NOTE: All other health insurances except Medicaid and CHAMPUS supplemental plans must pay before CHAMPUS supplemental plans, you must first submit the claim to the other health insurer and after that insurance has determined their payment, attach the other insurance Explanation of Benefits *(EOB)* or work sheet to the CHAMPUS claim. *The CHAMPUS claims processor cannot process claims until you provide the other health insurance information.*

12. The patient or other authorized person must sign the claim. If the patient is under 18 years old, either parent may sign unless the services are confidential and then the patient should sign the claim. If the patient is 18 or older, but cannot sign the claim, the person who signs must be either the legal guardian, or in the absence of a legal guardian, a spouse or parent of the patient. If other than the patient, the signer should print or type his/her name in Block 12a. and sign the claim. Attach a statement to the claim giving the signer's full name and address, relationship to the patient and the reason the patient is unable to sign. Include documentation of the signer's appointment as legal guardian, or provide your statement that no legal guardian has been appointed. If a power of attorney has been issued, provide a copy.

TFMDP CLAIM FORM

There are numerous claim forms used to process dental claims. To expedite processing, the Government will utilize the existing continental U.S. (CONUS) TFMDP claim form. The following suggestions for filling out the dental claim form will help to minimize problems and reduce delays in claims processing by the TRICARE contractor. A copy of the dental claim form and a sample of a completed form are also provided.

FILLING OUT A TFMDP DENTAL CLAIM FORM

Most of the blocks on the dental claim form are self-explanatory (see completed example below). But, there are certain blocks to which special attention should be paid as noted below:

Block above Block 1--If the provider or sponsor/family member wishes to obtain a pre-treatment estimate (or predetermination) of the services they would like performed, they should check the box marked "Dentist's pre-treatment estimate". When a pre-treatment estimate is checked, no dates of service should be listed in Block 27, Examination and Treatment Plan. If the provider or sponsor/family member wishes to submit a claim for the actual services rendered, they should check the box above block 1 marked "Dentist's statement of actual services".

Block 1--Only one patient per claim form. But you may attach more than one bill for the same patient. Be sure to use the name as it appears on the patient's ID card--or, for young children, as entered in DEERS.

Block 4--Be sure to enter the patient's birth date here.

Block 5--Indicate if family member is a full time student and, if so, where.

Block 7--Be sure the **Uniformed Services sponsor's** Social Security number is entered.

Block 8--Enter the complete home address of the family member seeking treatment. Indicate APO/FPO or street, city, country and appropriate postal mailing code.

Block 9--Put the sponsor/family member's complete daytime and evening phone numbers in this block so that these parties can be contacted if there is a problem with the claim. Include country and city codes as appropriate.

Signature block immediately under Block 9--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor. Be sure to read the instructions in the TFMDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

Block 12--If the sponsor/family member has any **other dental insurance** at all, such as a spouse's plan through an employer, check "yes". Give the name and address of the other dental insurance carrier, the insured's social security number, and the other insurance carrier's group number in the space provided. If the sponsor/family member has no other dental plan besides the TFMDP, check the "no" box.

Signature block immediately under Block 12--This block must be signed and dated by the patient (18 years of age or older) or the parent/guardian if the patient is a minor, if either party wants the provider to receive payment directly ("assignment"). Be sure to read the instructions in the TFMDP Dental Benefit Booklet if someone other than the patient is signing on behalf of the patient.

Block 13--This should be the provider's complete name.

Block 14--This should be the provider's complete mailing address, to include street, city, country and appropriate postal mailing code.

Block 15--This should be the provider's complete commercial phone number, to include country and city codes.

Blocks 17, 18 & 19--Complete based on information available from the provider, beneficiary and/or other information on itemized provider bill.

Blocks 20, 21 and 22--If the problem for which the family member went to the provider is work related or accident related (i.e., occupational illness/injury, auto accident, other injury), check the corresponding "yes" in Blocks 20, 21 or 22. If "yes", please provide a brief description and the date(s) of the incident. The contractor will follow up with some questions to make sure that worker's compensation or other insurance helps pay the bills.

Blocks 24 and 25--Answer only if the service is for a prosthetic device. Check with the provider for this information.

Block 26--Indicate "yes" if treatment is for orthodontics. If "yes", insert the date the orthodontic appliance was inserted and the expected length of the overall orthodontic treatment plan. Check with the sponsor/family member or provider for this information.

Block 27--From the provider's itemized bill or other available information, provide as much detail to indicate the service(s) that was ordered, performed or prescribed, the specific tooth/teeth treated, and the date(s) of service. Match services with specific tooth numbers to the greatest extent possible. For each service listed, provide the condition for which the patient received treatment and/or the procedure that was performed (attach additional pages as necessary), and the provider's fee that is being charged for each service.

Signature block immediately under Block 27--This block must be signed and dated by the provider.

NOTE: A “Non-Availability and Referral Form” must accompany the claim form and provider's itemized bill for all dental care from non-remote countries and for orthodontic care from remote countries (see the OCONUS TFMDP Authorization and Referral Manual for further information). This form is issued by the family member’s servicing ODTF or the appropriate Overseas Lead Agent or designee, depending on where the family member lives and the services that are performed.

ATTENDING DENTIST'S STATEMENT

Check One: ☐ Dentist's pre-treatment estimate ☐ Dentist's statement of actual services

PATIENT INFORMATION

1. Patient name
2. Relationship to sponsor: self / spouse / child / other
3. Sex: m / f
4. Patient birthdate: mo / day / year
5. If full time student: school / city
6. Sponsor's name: First / middle / last
7. Sponsor's social security no.
8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)
9A. DaytimeTelephone number
9B. EveningTelephone number
10. Branch of service
11. Group name: TRICARE Family Member Dental Plan
12. Is patient covered by another dental plan? ☐ yes ☐ no — Dental plan name; Insured soc. sec. no.; Group no.; Name and address of carrier

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. *

Signature (patient or parent if minor) — Date

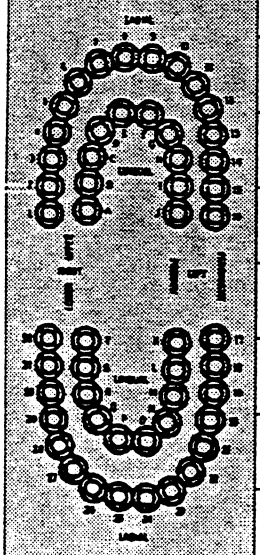
I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.

Signature (insured person) — Date

DENTIST INFORMATION

13. Dentist name
14. Mailing address — City, country, postal mailing code
15. Dentist phone no.
17. First visit date current series
18. Place of treatment: Office / Hosp. / ECF / Other
19. Radiographs and/or documentation enclosed? No / Yes / How Many?
20. Is treatment result of occupational illness or injury? No / Yes — If yes, enter brief description and dates
21. Is treatment result of auto accident?
22. Other accident?
23. Are any services covered by another plan?
24. **If prosthesis, is this initial placement?** — **(If no, reason for replacement)** — **25. Date of prior placement**
26. Is treatment for orthodontics? — Appliance insertion date — Total length of treatment

Identify missing teeth with "X"



28. Remarks for unusual services

27. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED MO.	DAY	YR	PROCEDURE CODE	FEE CHARGED	AMOUNT PAID

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or federal law and may also be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed.*

Signature (Dentist) — Date

TOTAL FEE CHARGED

AMOUNT PAID

5678 2/99 OCONUS

** Both signatures are required by the TFMDP contract or processing will be delayed.*

ATTENDING DENTIST'S STATEMENT

Check One: ☐ Dentist's pre-treatment estimate ☑ Dentist's statement of actual services

PATIENT SECTION

1. Patient name	2. Relationship to sponsor (self / spouse / child / other)	3. Sex (m / f)	4. Patient birthdate (mo / day / year)	5. If full time student (school / city)
Jane J. Doe	X	X	10 / 27 / 57	Education University, Frankfurt

6. Sponsor's name (First / middle / last)	10. Branch of service
James T. Doe	Army
7. Sponsor's social security no.	**11. Group name**
999-99-9999	TRICARE Family Member Dental Plan

8. Patient mailing address (APO/FPO or street, city, country, postal mailing code)
Box 1267
APO AE 01234 (Germany)

12. Is patient covered by another dental plan? ☑ yes ☐ no — Dental plan name: Dental Insurance Company
Insured soc. sec. no.: 111-11-1111 — Group no.: 000123450
Name and address of carrier: Dental Insurance Company, 1415 Main Street, Chicago, IL

9A. DaytimeTelephone number	9B. EveningTelephone number
(011)0711-638472	(011)0711-527361

I have reviewed the following treatment plan. I authorize release of any information relating to this claim. *
PATIENT OR PARENT/GUARDIAN SIGN HERE — Signature (patient or parent if minor) — Date: 1/5/99

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to the dentist listed below.
PATIENT OR PARENT/GUARDIAN MUST SIGN HERE IF HE/SHE WANTS PAYMENT TO GO TO DENTIST — Signature (insured person) — Date: 1/5/99

DENTIST SECTION

13. Dentist name
Dr. Franz Schmidt

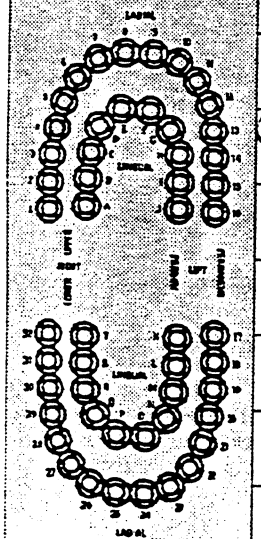
14. Mailing address
Kabingstrase 30
City, country, postal mailing code
54270 Fürth (Germany)

15. Dentist phone no.
(011) 1487-639-465

20. Is treatment result of occupational illness or injury?	No	Yes	If yes, enter brief description and dates
21. Is treatment result of auto accident?	✓		
22. Other accident?	✓		
23. Are any services covered by another plan?		✓	
24. If prosthesis, is this initial placement?	✓		(If no, reason for replacement) — **25. Date of prior placement**
26. Is treatment for orthodontics?	✓		Appliance insertion date — Total length of treatment

17. First visit date current series	18. Place of treatment (Office / Hosp. / ECF / Other)	19. Radiographs and/or documentation enclosed? (No / Yes)	How Many?
1/5/99	X	✓	

Identify missing teeth with "X"



27. Examination and treatment plan-list in order from Tooth No. 1 through Tooth No. 32 - Use charting system shown.

TOOTH NO. OR LETTER	SURFACE	DESCRIPTION OF SERVICES (INCLUDING X-RAYS, PROPHYLAXIS, MATERIALS USED, ETC.)	DATE SERVICE PERFORMED (MO / DAY / YR)	PROCEDURE CODE	FEE CHARGED	AMOUNT PAID
		(B) Examination	(C) 1 / 5 / 99		(D)	
(A) 12		(B) Filling on one surface	(C) 1 / 5 / 99		(D)	
		Note: If the claim form is used as the dentist's bill, then include the following information as shown above (A) tooth number (B) description of services provided (C) date of service (D) fee charged (If individual fee service charge is known, please enter. If not known, enter total fee charged.)				
		Note: If services are listed on the dentist's bill, attach the bill to this claim. You do not need to complete this section.				

28. Remarks for unusual services

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete, misleading information or conceals for the purpose of misleading, information concerning any fact material thereto, may be guilty of a criminal act under state and/or federal law and may also be subject to civil penalties. I hereby certify that the procedures as indicated by date have been completed. *
Dentist must sign here unless bill is attached and dentist's name is listed on the bill. — Signature (Dentist)
Complete unless date is on the attached bill — Date

TOTAL FEE CHARGED (D) 50 DM — AMOUNT PAID

5678 2/99 OCONUS

* Both signatures are required by the TFMDP contract or processing will be delayed.

Completing the TFMDP OCONUS Claim Form

Most of the TFMDP OCONUS Claim Form is self-explanatory,- however, there are certain fields to which special attention should be paid.-

- **Upper left corner** ("Attending Dentist's Statement"): Check the appropriate box to indicate if your claim is for predetermination (estimate of services to be performed) or for services actually received.
- **Sponsor's ID (Field 6)**: The sponsor's nine-digit Social Security Number (SSN) **must** appear on every family member's claim form.
- **Patient's mailing address (Field 8):** Be sure to provide the current and complete mailing address to include APO/FPO and/or street city, country and postal mailing code.
- **Telephone number (Field 9)**: Enter the patient's daytime and evening telephone number including applicable city and country codes.
- **Area below field 9**: **Must** be signed bv the patient, parent or guardian. If the family member is under 18 years old, the parent or guardian must sign the form.
- **Is the patient covered by another dental plan? (Field 12):** Check "No" if the family member has no other dental insurance. If the family member has additional dental insurance, please check "Yes" and include the plan name, SSN, group number, and address of the other carrier.
- **Area below field 12:** Sign **if** the family member, parent, or guardian wants to assign payment of benefits to the dentist. This means that the TFMDP contractor will send payment directly to the dentist.
- **Dentist's address (Field 14):** Enter the dentist's complete mailing address to include street, city, country and postal mailing code.
- **Dentist's phone number (Field 15):** Provide the dentist's telephone number including all applicable city and country codes.
- **Examination and Treatment Plan (Field 27):** Provide a detailed description of the services performed including applicable tooth number(s), the date of service, and the fee charged. If services and fees are listed on the dentist's bill, attach the bill to this claim form. In this case, you do not need to duplicate the information in this section.
- **Bottom left corner:** The dentist must sign and date here **if** this claim form is used solely as the dentist's bill. If a bill is submitted with the claim form, and the bill clearly identifies the dentist, the dentist's signature is not required.

General Instructions

- Submit a separate claim form for each family member who receives treatment.
- All claim forms should be submitted to the TFMDP contractor as soon as possible after the service date, preferably within 60 days of the date of service. Claims postmarked more than 12 months after the date of service will be denied.
- The family member must sign the appropriate sections of the claim form. If the family member is under 18 years old, the parent or guardian must sign the form.
- If you receive care in a **non-remote** country, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider's bill to the address on the front of this form.
- For orthodontic care in **remote** countries, submit a completed copy of this claim form along with a valid Non-Availability and Referral Form and the provider’s bill to the address on the front of this form. For non-orthodontic care, only the completed claim form and the provider's bill is required.

Remember

You must submit the following information:

1) A completed claim form.
2) The dentist's bill (if the claim form is not used solely as the bill).
3) A Non-Availability and Referral Form (except for non-orthodontic care in remote locations).

If all necessary information is not included, your claim will be denied.